INDIANA
BREAST & CERVICAL
CANCER PROGRAM (IN-BCCP)
PROVIDER MANUAL

FORWARD

The Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP), was created in response to the Breast and Cervical Cancer Mortality Prevention Act passed by Congress in 1990. The NBCCEDP is both the first and, thus far, the only national cancer screening program in the United States. The NBCCEDP is a comprehensive public health program that helps uninsured and underserved participants gain access to screening services for the early detection of breast and cervical cancer.

In Indiana, the Breast and Cervical Cancer Program (IN-BCCP) provides funding for breast and cervical cancer screening services. Screening services are contracted through Indiana medical providers and include clinical breast examinations, mammograms, and Pap tests for eligible participants, as well as diagnostic testing for participants whose screening outcome is abnormal. Participants needing treatment are referred to Hoosier Healthwise (Medicaid Category MA-12), which was created with the passage of the Indiana Breast and Cervical Cancer Treatment Act.

The target population for IN-BCCP breast cancer screening services is women between the ages of 50 and 64 who are low-income (up to 200 percent of the federal poverty level), who have not been screened in the past year, and who have no other source of health-care reimbursement that covers screening services such as insurance or Medicaid. The eligible population for IN-BCCP cervical cancer screening services is women between the ages of 40 and 64 who are low-income (up to 200 percent of federal poverty level), who have never been screened or have not been screened in the past five years, and who have no other source of health-care reimbursement that covers screening services, such as insurance.

Policies and protocols of IN-BCCP are not intended to direct clinical practice management, limit patient care, or interfere with practice policies of individual providers. However, IN-BCCP policies and protocols must be adhered to in order to ensure appropriate use of program funding for IN-BCCP enrolled participants. Provider discretion may be used to provide services beyond the established policies and protocols, but IN-BCCP will not reimburse for those services. Providers may not bill IN-BCCP enrolled participants for the difference between what the program pays and what the provider would normally charge. IN-BCCP policies and protocols are in accordance with recommendations from the CDC and the NBCCEDP.

IN-BCCP POLICY
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I. PERFORMANCE STANDARDS

A. Goal

1. IN-BCCP is primarily a screening program for the early detection of breast and cervical cancer in participants age 40 through 64 who are medically underserved due to financial constraints. For this reason, participants must be verified as eligible for program services and must be enrolled prior to receiving a screening procedure (clinical breast exam (CBE), screening mammogram, Pap/cervical cancer screening tests or pelvic exam when indicated). Only participants who have been properly enrolled into IN-BCCP will be eligible for covered screening, diagnostic, and case management services offered through the program.

B. Target and Priority Populations

1. Participating IN-BCCP enrollment site providers should be prepared to offer both breast and cervical cancer screening services to participants within the IN-BCCP target population. IN-BCCP places a strong emphasis on participants who are rarely (more than five years) or never screened, who live in rural areas, and/or who are racial and ethnic minorities.

II. ELIGIBILITY GUIDELINES

A. Eligibility for Program Participation

1. Decided by age, state of residency, and income

a. Indiana residents, age 40 and over;
b. Female or male-to-female transgender persons, who are taking or have taken hormones (contact your case manager to manage on a case by case basis);
c. Income: 200 percent of poverty level or below
d. Insurance
   i. Uninsured
   ii. Participants covered by other federal programs, such as full coverage Medicaid or Medicare Part B, are not eligible for services through IN-BCCP.

B. Eligibility for Screening Services

1. Persons under age 40

a. Persons less than 40 years of age are <u>not eligible</u> for any IN-BCCP reimbursable services. Due to limited resources, exceptions cannot be made for any reason allowing younger persons to be enrolled in the program.

2. Participants age 40 through 49

a. Properly enrolled IN-BCCP participants age 40 through 49 are generally eligible for an office visit, Pap test *(Refer to the Cervical Screening Services Delivery)* with pelvic exam and CBE *(Refer to Section IV).*
b. Participants age 40 through 49 who have had an IN- BCCP paid CBE and screening Pap, and are not eligible for another IN-BCCP paid screening Pap for 3 or 5 years, depending on whether a Pap alone or co-testing was used, may have an annual CBE and pelvic exam in the intervening years as long as they remain eligible for BCCP, including cervical eligibility. However, once

the participant is due for another BCCP paid Pap, it must be done in order to qualify the participant for a CBE. (*Refer to Cervical Screening Services Delivery*).

c. ***Exceptions***:
    i. Participants age 40 through 49 who had a BCCP paid Pap/cervical cancer screening test and/or presented with breast symptoms, or have a personal history of breast cancer, are entitled to a CBE. Those participants with a normal CBE are not eligible for an IN-BCCP reimbursable screening mammogram. IN-BCCP is aware of, and supports, recommendations that encourage screening mammograms for participants 40 through 49 years of age. However, due to CDC funding guidelines and research indicating older women to be at higher risk of mortality due to breast cancer, IN-BCCP is unable to reimburse for screening mammograms for participants less than 50 years of age. If other funds (Komen, Avon, private pay, etc) can pay for the screening mammogram, IN-BCCP may reimburse for additional recommended BCCP allowable diagnostic tests. (Contact the appropriate Regional Coordinator for local resources.) These participants will be eligible to apply for treatment funds through Hoosier Healthwise (MA12) if treatment is indicated. If an IN-BCCP paid CBE is suspicious for cancer, that participant will be eligible to receive a diagnostic mammogram and indicated follow-up procedures to be paid by the program.
    ii. Sometimes a participant in her forties will present with a breast complaint when she arrives for her screening mammogram and is subsequently told by the imaging site that her mammogram must be changed to a diagnostic. IN-BCCP cannot pay for the diagnostic mammogram in that situation, however, the participant has the option of postponing the imaging and asking to be re-examined by the IN-BCCP provider who did the original CBE, and if the new CBE results in a suspicious finding, IN-BCCP can then pay for a diagnostic mammogram for the participant.

3. Participants age 50 and older

a. Properly enrolled IN-BCCP participants age 50 and older are generally eligible for all IN-BCCP reimbursable screening services including: office visit, CBE, Pap test (*Refer to the Cervical Screening Services Delivery*) with pelvic exam when indicated, and mammogram. "Properly enrolled" means participants MUST BE verified as being eligible for program services, enrolled prior to receiving an IN-BCCP reimbursable screening procedure, and have a valid signature on file *(Refer to Section III-A).*

4. Participants age 65 and older

a. IN-BCCP can provide screening services to eligible participants age 65 and over, however it is important to note that Medicare Part B, which many of this age group has, makes them ineligible for IN-BCCP. If this age group needs treatment, Hoosier Healthwise (MA12) is not a viable resource. If interested in Medicaid, the participant would need to contact Family and

Social Service Administration (FSSA) to determine eligibility for another category of Medicaid.

5. Males are ineligible for any IN-BCCP reimbursed services unless they are transgender male-to-females who have taken, or are taking hormones.

C. Eligibility for Special Enrollment

Those providers identified as special enrollment sites should contact the appropriate Regional Coordinator for questions or concerns specific to these enrollments.

D. Eligibility for Diagnostic Services

1. Properly enrolled IN-BCCP participants who require further evaluation of abnormal screening test results will be eligible for pre-approved diagnostic services and case management paid by IN-BCCP.

2. Participants WILL NOT be allowed to enroll into IN-BCCP at the diagnostic stage after a problem is identified. This includes persons who have already had a screening procedure outside of the IN-BCCP and would enter the program needing additional mammographic views, breast ultrasounds, consultations, breast biopsies, colposcopies with or without biopsies, endometrial biopsies, and diagnostic LEEP/conization.

3. A **Pre-authorization for Diagnostic Services** form must be submitted to an In-BCCP RN-Case Manager for PRIOR approval of any diagnostic procedure (*Refer to Section III-D, Request for Diagnostic Services*).

III. ENROLLMENT & REIMBURSEMENT GUIDELINES

A. Proper Participant Enrollment

1. Participants must be enrolled in IN-BCCP PRIOR to having a screening procedure (CBE, mammogram, Pap/cervical cancer screening tests or pelvic exam), and must have a valid signature on file. According to Indiana state law IC 16-39-1-1, a participant's signature is only valid for sixty (60) days.

2. Program reimbursable services must be rendered by IN-BCCP participating medical providers as evidenced by a current **Indiana State Department of Health, Breast and Cervical Cancer Program Provider Agreement**, as well as by signed letters of intent from all participating physicians, physicians' assistants, and nurse practitioners.

3. IN-BCCP Providers
   - **a.** Must ensure that participants provide all necessary program enrollment information.
   - **b.** Must ensure that participants are eligible for both the program and the services being provided.
   - **c.** Should notify participants beforehand of any specific services and procedures that WILL NOT be covered by the IN-BCCP (*Refer to Current Procedural*

Terminology (CPT) Code listing provided by IN-BCCP for program covered services.).

4. Appropriate data and test results must be collected and submitted in order for claims to be processed. The IN-BCCP enrollment forms (**Screening and Diagnostic**) must be completed in their entirety. The **Screening Visit Summary** page and the **Diagnostic Visit Summary** page MUST be completed by the clinician. The "Visit Summary" section, including the patient history and services provided, must be completed by the provider or site representative; this section is not intended for the patient to fill out. (*Refer to the IN-BCCP enrollment forms and the instructions for completing the IN-BCCP enrollment forms, Section VII.*)

B. Reimbursement for Services Provided by Participating Providers

1. Services MUST be rendered by IN-BCCP participating medical providers. IN-BCCP CANNOT reimburse for services performed OUTSIDE the IN-BCCP provider network.

2. In order to receive payment for services, a completed IN-BCCP enrollment packet which includes corresponding reports such as cytology, radiology, pathology reports, and consultation notes must be received by the Regional Office within 30 days of the date of service.

3. All IN-BCCP participating providers consent through their provider agreement to accept only those amounts specified for each approved CPT code (*Refer to the current CPT listing provided by the program.*) Providers MUST agree not to bill IN-BCCP participants the difference between provider fees and the amount reimbursed by the program for IN-BCCP covered services. Providers should notify participants of their individual financial responsibility for non IN-BCCP covered procedures prior to delivering services. IN-BCCP does not cover co-pays.

4. IN-BCCP reimbursable CPT codes are reviewed and distributed annually and adjusted in accordance with the current Medicare rates. Adjustments usually occur at the beginning of the IN-BCCP fiscal year (June 29).

5. Refer to the CPT code listing provided by IN-BCCP for program covered services.

C. Processing and Submitting Claims

1. Bills are to be submitted to the designated IN-BCCP regional office. Billing questions may be directed to your IN-BCCP regional coordinator.

2. Claims must be submitted promptly. Any claims older than 90 days from the date of service may be denied.

3. For IN-BCCP participants with insurance, a claim must be filed with the insurance company FIRST; a copy of the EOB should be submitted to IN-BCCP. IN-BCCP will calculate reimbursement based on EOB payments and Medicare allowable rates.

4. IN-BCCP funds must be used as a payment of last resort.

D. Request for Diagnostic Services

1. A **Pre-Authorization for Diagnostic Services** form (*Refer to Forms Instructions Section VII*) must be faxed to an IN-BCCP RN-Case Manager for approval PRIOR to a diagnostic procedure to ensure payment. In addition to the pre-authorization, page three and the completed Visit Summary (back page) of the **Screening Enrollment or Diagnostic Visit** form, the abnormal report if applicable, and office visit notes that clearly describe the CBE findings must be submitted along with the **Pre-Authorization for Diagnostic Services** form. If an IN-BCCP participant is waiting in the provider's office for an immediate procedure, the provider or site representative may call the assigned case manager to request a verbal approval. A **Pre-Authorization for Diagnostic Services** form, with the verbal approval noted, is expected to be faxed to central office within the same business day to ensure reimbursement. A copy of the approved **Pre-Authorization for Diagnostic Services** form should be submitted with the completed enrollment packet.

2. IN-BCCP RN-Case Managers are assigned to provide services in specific counties. The phone numbers for the case managers will be listed on the **Pre-Authorization for Diagnostic Services** form.

3. All referrals for diagnostic testing must be made to IN-BCCP participating providers in order for services to be reimbursed by the program. (Contact your IN-BCCP regional coordinator for a list of participating providers in your area.)

E. Services Not Reimbursed

1. There may be additional, non-reimbursable services routinely provided at the time of a reimbursable IN-BCCP service. This is especially true for a benign biopsy, which does not qualify a participant for Medicaid. Anesthesia and supplies are examples of two of the services not payable by IN-BCCP. To ensure that participants understand what their costs will be for a biopsy, please refer to the Medicare CPT Codes and Prices document.

IV. BREAST SCREENING SERVICE DELIVERY

A. Protocol for an Office Visit and CBE

1. A physical assessment to include a thorough breast examination should be performed on all eligible participants enrolled in IN-BCCP who present for a Pap/cervical cancer screening test and/or mammogram. CBE findings and self reported symptoms should be documented in both the site's medical record and the appropriate section of the IN-BCCP **Screening Enrollment** Form (Visit Summary). Clinical notes must correspond to the CBE findings recorded on the IN-BCCP Visit Summary page.

2. A Physician, Advanced Practice Nurse Practitioner (APNP), or Physician Assistant (PA) MUST perform all aspects of the physical examination. A current IN-BCCP provider agreement and letters of intent for these positions MUST be on file with IN-BCCP, either directly or with the entity employing them.

3. All participants are encouraged to have a CBE during the same office visit that a Pap/cervical cancer screening test is being performed. A woman age 40 through 49 is

not eligible for a cervical cancer screening in the absence of a cervix as a result of a hysterectomy for benign reasons. She is not eligible for a CBE unless she presents with breast symptoms, or has a personal history of breast cancer. A complaint of breast symptoms must be reported prior to the CBE and clearly documented on the **Screening Enrollment Form** and documented in the clinic notes. (Records noting symptoms may be targeted for close monitoring.) A woman should not be given a Pap test if she is not due for one simply to make her eligible to receive an IN-BCCP paid CBE.

4. Written office/progress notes which include the CBE results must accompany page four of the **Screening Enrollment Form** when requesting pre-authorization for diagnostic services.

B. Protocol for Mammography Services (Screening and Diagnostic)

1. Eligible participants age 50 and older may receive a mammogram to be paid by IN-BCCP regardless of their CBE findings and Pap/cervical cancer screening test eligibility. Eligible participants age 50 and older may be invited to return annually (no less than 12 months plus one day) for mammography services.

2. Participants age 40 through 49 are not eligible to receive screening mammograms through IN-BCCP. They are eligible for a diagnostic mammogram if their IN-BCCP paid CBE is suspicious for cancer, marked on the IN-BCCP **Screening Enrollment Visit Summary**, and verified by the clinical notes. They are also eligible for a diagnostic mammogram if they had an IN-BCCP paid CBE which was "not suspicious for cancer", and was followed by an abnormal screening mammogram paid through other funds. In addition, they are also eligible for a diagnostic mammogram if they have a personal history of breast cancer, or if they need a short interval follow-up and the mammogram and/or ultrasound necessitating the short interval follow-up were paid by IN-BCCP.

3. IN-BCCP recommends that a CBE be performed prior to eligible participants receiving annual mammograms through the program. Participants age 40 through 49 MUST have a CBE in order to be eligible for an IN-BCCP paid mammogram and any indicated diagnostic follow-up.

4. IN-BCCP will pay for screening mammograms ordered for eligible asymptomatic participants age 50 and over with normal CBE findings. Diagnostic mammograms should be ordered after "suspicious for cancer" CBE findings, for those with a personal history of breast cancer, or for those who need short interval follow-up.

   Reminder: A **Pre-Authorization for Diagnostic Services** form must be submitted to an IN-BCCP RN Case Manager (*see VI-A*) PRIOR to performing a diagnostic mammogram, including short-interval follow-up mammograms and other IN-BCCP approved diagnostic procedures.

   a. Exception (40 through 49): Participants age 40 through 49 presenting for a short term follow-up diagnostic mammogram and/or ultrasound are ineligible for services reimbursed by IN-

BCCP UNLESS the services for which short interval follow-up is required were paid by IN-BCCP.

b. Exception (50 and older): Participants age 50 and older, if not previously enrolled, can be enrolled into the program at specific IN-BCCP mammography sites which have completed the process to become a Special Enrollment Site for the program. These women may or may not have had a CBE by a non-participating BCCP provider. (*Refer to the "Eligibility for Special Enrollment" regarding mammography site enrollment, Section II.*)

5. Follow-up of all abnormal results is required until a definitive diagnosis is reached. IN-BCCP participants must receive diagnostic tests in a timely manner. A final diagnosis must be obtained within 60 days of the abnormal screening date, and treatment, if deemed necessary, must be initiated within 60 days of the date of the final diagnosis.

6. An office visit is not needed prior to a short interval follow-up mammogram unless the participant is due for her annual enrollment or reports new breast symptoms.

C. Protocol for Reimbursable Breast Services

1. IN-BCCP will reimburse providers for the following services at the rates specified in the current IN-BCCP Screening and Diagnostic Services Medicare CPT Codes and Prices list.

a. Non Pre-Authorization Services

i. Initial Clinical Breast Exam (CBE)

ii. Screening Mammogram

b. Pre-Authorization Services

A **Pre-Authorization for Diagnostic Services** form must be submitted to the appropriate IN-BCCP RN Case Manager prior to these procedures:

i. Diagnostic Mammogram
ii. Breast Ultrasound
iii. FNA-Cyst Aspiration
iv. Biopsy (excisional, incisional, core, stereotactic, mammatome)
v. Surgical consultations/Repeat CBE
vi. Ductograms –effective 6/30/14
vii. MRI's – effective 6/30/2014

MRI to be used *ONLY* in conjunction with:

1. A mammogram for an enrolled woman with a documented BRCA mutation; *OR*

2. A first degree relative who is a documented BRCA carrier; *OR*

3. A personal lifetime risk of equal to or greater than 20-25% as indicated and documented by breast cancer risk assessment models such as BRCAPRO that focus on family history.

MRI is *NOT* intended to be used as a stand-alone screening tool and cannot be reimbursed to assess the

extent of disease after an enrolled woman has been diagnosed with breast cancer. It is *IMPERATIVE* that breast MRI is done at facilities with dedicated breast MRI equipment and that can perform MRI guided breast biopsies. Contact your IN-BCCP regional coordinator for a list of IN-BCCP approved MRI facilities in your area.

c. IN-BCCP will **NOT** reimburse for the following:
   i. Computer Aided Detection (CAD)

V. CERVICAL SCREENING SERVICE DELIVERY

The following cervical policy pertains to IN-BCCP reimbursed cervical screening tests only and is based on United State Preventative Services Task Force (USPSTF), American Cancer Society (ACS), American Society for Colposcopy and Cervical Pathology (ASCCP) and American Society for Clinical Pathology (ASCP) guidelines.

A. Protocol for Cervical Cancer Screening Tests

For women age 40-65 with a cervix, and without a history of high-grade cervical lesions (CIN 2 or 3) or cervical cancer, and are not immunocompromised, not HIV positive, and were not exposed to diethylstilbestrol in utero.	Screen every three years with cytology (Pap/LBT) alone OR every five years with cytology and high-risk HPV co-testing
For women 40-65 with history of high-grade lesions (CIN 2 or 3).	Screening for 20 years after the CIN 2/3 diagnosis on same schedule as above.
For women 40-65 with total hysterectomy (cervix removed) AND documentation from hysterectomy pathology which shows no high grade cervical lesions [CIN 2 or 3] or cervical cancer.	Do not screen.
For women 40-65 with total hysterectomy (cervix removed) but with no documentation of hysterectomy pathology.	Screen every three years with cytology (Pap/LBT) alone OR every five years with cytology and high-risk HPV co-testing.
For women 40-65 with history of cervical cancer.	Screen indefinitely, health permitting, every three years after a period of intense screening as follow-up per provider according to the extent of disease and/or ASCCP guidelines (IN-BCCP cannot pay for the period of intense screening).
For women 40-65 with documented high-risk status (HIV positive, immunocompromised and/or exposed to diethylstilbestrol in utero).	Screen annually.
For women over 65 who have had adequate prior screening AND are not high-risk.	Do not screen.

1. For recommendations regarding abnormal cervical cancer screening test findings please refer to ASCCP guidelines: *(See Appendix.)*

2. Providers may choose to perform testing other than that recommended by ASCCP, however, IN-BCCP can only reimburse for those services indicated in the ASCCP guidelines. If ASCCP guidelines are not followed, IN-BCCP reserves the right to refer the case to the IN-BCCP Medical Advisory Board for review or to an IN-BCCP provider for a second opinion.

B. Protocol for HPV DNA Testing

1. IN-BCCP reimburses HPV High Risk Panel DNA Testing when done as co-testing along with a Pap every five years. It can also be reimbursed when done reflexively following a Pap result of ASCUS or LSIL, when said Pap was done as an every three year screening Pap. Once any type of follow-up is needed after an abnormal or unsatisfactory screening result, or as follow-up post-colposcopy, HPV High Risk Panel DNA Testing will only be reimbursed when done according to ASCCP guidelines and with pre-authorization.

2. Genotyping is not a reimbursable service even if recommended by ASCCP as follow-up. (Please note: ASCCP offers other viable options. *See ASCCP algorithms*.)

C. Protocol for Reimbursable Cervical Services

1. IN-BCCP will reimburse providers for the following services at the rates specified in the current IN-BCCP Screening and Diagnostic Services Medicare CPT Codes and Prices list:
   a. Non Pre-Authorization Services – for routine screening
      i. Conventional method (Pap test)
      ii. Liquid-based cytology (i.e., Thin Prep® /Sure Path™)
   b. Pre-Authorization Services: A **Pre-Authorization for Diagnostic Services** Form along with pages three (3) and four (4) of the purple **Screening Enrollment** Form or both sides of the gray **Diagnostic** Form must be included with every pre-authorization request submitted to the appropriate IN-BCCP RN Case Manager prior to the procedure, (i.e., repeat Pap, colposcopy, diagnostic LEEP/conization, endometrial biopsy).

   c. When to Use a Pre-Authorization Form

Screening Pap every three years or co-testing every five years	No Pre-authorization is needed
Pap as a follow-up to: a) An abnormal Pap b) An unsatisfactory Pap c) A negative Pap where the EC/TZ is absent/insufficient d) A negative Pap with positive high-risk HPV e) A colposcopy for which treatment is not needed.	Pre-authorization is needed

Colposcopy, endometrial biopsy, diagnostic LEEP/cone Bx. High Risk HPV DNA testing when done other than as every five year co-testing.	

d. IN-BCCP will NOT reimburse for the following:
   i. Pelvic/transvaginal ultrasound
   ii. Biopsy of vulvar/vaginal lesions, if cervix is present
   iii. Polyp removal (without cytology)
   iv. Diagnostic work-up/treatment of ovarian cysts or masses
   v. Cryotherapy or other treatment services
   vi. Genotyping, even if recommended by ASCCP
   vii. Procedures not recommended by ASCCP or outside of ASCCP guidelines

VI. CASE MANAGEMENT SERVICES AND FOLLOW-UP PROTOCOL

A. Services Provided by Case Manager

1. IN-BCCP Case Managers are RNs who work with IN-BCCP providers in the area of Professional Education, Quality Assurance, and clarification of IN-BCCP policy. Case Managers follow enrolled participants with abnormal results to ensure that IN-BCCP policies are maintained, approve or deny requested diagnostic services, transition participants requiring treatment services to Hoosier Healthwise, and see that enrolled women receive timely and appropriate services.

B. Availability of IN-BCCP RN-Case Management Services

1. IN-BCCP participants with abnormal results as designated in this policy are entitled to case management services. IN-BCCP RN-Case Managers follow these participants through diagnostic work up and treatment if needed.

2. IN-BCCP participants who are experiencing barriers to care may also be referred for case management services. This includes women with transportation problems, language barriers, psychosocial problems and/or family issues. Every effort will be made to refer these participants to the appropriate resources.

C. Follow-Up Requirements

1. Follow-up of all abnormal results is required until a definitive diagnosis is reached. IN-BCCP participants must receive diagnostic tests in a timely manner. A final diagnosis must be obtained within 60 days of the abnormal screening date, and treatment, if deemed necessary, must be initiated within 60 days of the date of the final diagnosis.

2. It is the responsibility of the provider to obtain and forward all test results and consultation notes to the assigned IN-BCCP RN-Case Manager and Regional Coordinator as stated in the **IN-BCCP Provider Agreement**.

3. All referrals for diagnostic tests must be made to IN-BCCP participating providers in order for services to be reimbursed.

4. IN-BCCP participants who choose not to comply with the recommended plan of care will be classified as refusing follow-up and may be denied future IN-BCCP services.

D. Results Requiring Diagnostic Evaluation

1. Abnormal CBE, suspicious for cancer
   a. Palpable mass
   b. Bloody or serous nipple discharge – documented in clinic notes and in accordance with the current National Comprehensive Cancer Network (NCCN) Guidelines. *(See appendix for NCCN website information.)*
   c. Nipple or areolar scaliness
   d. Skin dimpling or retraction
   e. Pain – documented in clinic notes and in accordance with the October 31, 2013, IN-BCCP director's letter.

2. Abnormal mammogram
   a. Suspicious abnormality – (BIRADS 4)
   b. Highly suggestive of malignancy – (BIRADS 5)
   c. Assessment Incomplete – (BIRADS 0)

3. Abnormal Pap/Cervical Cancer Screening Tests
   a. Atypical Squamous Cell – cannot exclude High Grade lesion (ASC-H)
   b. Atypical Squamous Cells of Undetermined Significance plus positive HPV
   c. High Grade Squamous Intraepithelial Lesion (HSIL)
   d. Atypical Glandular Cells (AGC)
   e. Squamous cell carcinoma
   f. Low Grade Squamous Intraepithelial Lesion (LSIL), if positive HPV or if HPV not done
   g. Endometrial cells in women over 40 years of age (if indicated by menstrual status).

4. IN-BCCP cannot approve premature follow-up of unsatisfactory colposcopies, but with prior authorization, IN-BCCP can usually approve a diagnostic LEEP or cone in order to obtain a definitive diagnosis.

5. For recommendations regarding follow-up of abnormal Pap/cervical screening/diagnostic findings please refer to current *Algorithms from the Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities.* For recommendations regarding follow-up of abnormal CBE findings refer to current National Comprehensive Cancer Network Breast Cancer Screening and Diagnosis guidelines. (*See Appendix*)

E. Cervical Diagnostic Results Requiring Treatment Services

Treatment is required for any diagnostic result of CIN II or worse. CIN I may or may not be treated depending on the recommendation of the provider. For those providers who do an EBC (endocervical brushing) instead of the more traditional ECC (endocervical curettage) as part of their colposcopy procedure, an EBC finding of ASC-H or HSIL requires treatment, whereas a finding of ASCUS, LSIL, or AGUS may or may not be treated depending on the recommendation of the provider.

F. Follow-up Protocol for Abnormal CBE Findings

1. In the case of a CBE that is suspicious for cancer, followed by a negative/benign mammogram and/or ultrasound, further clinical evaluation of the abnormality is necessary and must be performed. False negatives are reported in 10-20 percent of all mammograms which must be confirmed as benign by a repeat breast exam, surgeon's evaluation, successful cyst aspiration/FNA, or a biopsy before a negative diagnosis can be assured.

2. Mammograms and ultrasounds ordered by primary providers following a repeat CBE where a mass or other suspicious finding is still detected cannot be paid by IN-BCCP. The program recommends these women be referred to an IN-BCCP surgeon prior to a second diagnostic work-up.

3. If a palpable finding corresponds to simple cyst as stated in an ultrasound report, the surgical consultation, repeat breast exam, or biopsy may be waived.

D. IN-BCCP RN-Case Management Referrals for Treatment Services

1. Treatment must be initiated within 60 days of a diagnosis of cancer or a precancerous condition that requires treatment.

2. Treatment services are available through a special category of Medicaid/Hoosier Healthwise for most eligible IN-BCCP participants who are screened and diagnosed with breast cancer, cervical cancer or an approved precancerous condition within IN-BCCP. Providers must notify the assigned IN-BCCP RN-Case Manager of the participant's diagnosis and complete a **Pre-Authorization Treatment Request** form.

3. The **Pre-Authorization Treatment Request** form should be faxed to the IN-BCCP RN-Case Manager assigned to your region, along with a copy of the breast or cervical pathology report. A copy of the pathology report must be received before the Medicaid application can be mailed to the participant.

4. IN-BCCP RN-Case Managers will mail treatment application materials directly to the participant for completion. Completed applications will be returned to the IN-BCCP office with proof of citizenship and state residency, and then forwarded to the Hoosier Healthwise office.

5. Completed applications are forwarded to Hoosier Healthwise with a Certificate of Verification that contains information regarding the participant's enrollment status and diagnosis. A Hoosier Healthwise caseworker contacts the IN-BCCP participant by phone for additional information and informs the participant and the IN-BCCP

RN-Case Manager of approval or denial for coverage. The IN-BCCP RN-Case Manager will notify the provider of the participant's status. Hoosier Healthwise will send a Medicaid card to the participant, if approved. This will provide the participant with full Medicaid coverage until the patient's provider determines that active treatment is complete.

6. Participants MUST be referred to Medicaid providers in order for treatment services to be reimbursed through Hoosier Healthwise. The Medicaid caseworker will assist the participant in identifying local healthcare providers who offer services to Medicaid clients.

7. IN-BCCP participants who do not qualify for Medicaid, and have no other medical coverage, will be assisted by the IN-BCCP RN-Case Manager and provider to obtain appropriate, affordable treatment.

H. Cervical Treatment Services

1. The following are some of the cervical treatment procedures reimbursed through this category of Hoosier Healthwise, Category MA-12. All related costs, such as hospitalization, pre-op lab work, and anesthesia are also covered through MA-12.
    a. Hysterectomy
    b. LEEP
    c. Conization
    d. Cryotherapy
    e. Laser Vaporization
    f. Radiation
    g. Prescription Medication

2. An MA-12 eligible participant remains on Hoosier Healthwise until such a time that the MA-12 caseworker determines the participant is no longer eligible. Holistic, homeopathic, and experimental treatment options cannot be covered by Medicaid.

I. Breast Treatment Services

1. The following are some of the options for breast treatment services covered by MA12 for atypical ductal hyperplasia, carcinoma in situ, invasive or inflammatory breast cancer. All related costs, such as hospitalization, pre-op lab work, anesthesia, and reconstructive surgery may be covered as well.
    a. Lumpectomy
    b. Mastectomy (partial or modified radical)
    c. Sentinel Node Biopsy
    d. Chemotherapy
    e. Radiation
    f. PET Scans
    g. Bone Scans
    h. Estrogen-blocking Therapy
    i. Prescription Medication

j. Breast reconstruction

2. An MA-12 eligible participant remains on Hoosier Healthwise until the MA-12 Medicaid caseworker determines the participant is no longer eligible. As with cervical cancer treatment, holistic, homeopathic, and experimental treatment options cannot be covered by Medicaid.

VII. FORM INSTRUCTIONS

A. Completion of the Screening Enrollment Packet

1. The IN-BCCP Screening Enrollment Packet consists of the English (Purple) or the Spanish (Ivory) **Screening Enrollment** Form, The HIPAA Notice of Privacy Practices (Yellow-English, Salmon-Spanish), Breast Imaging Summary (Pink), and the Pap Summary (Blue).

2. All **Screening Enrollment** Forms (English/Purple and Spanish/Ivory) must be signed and dated by the participant. A participant's signature is only good for 60 days. Please note a participant's signature is now needed on the bottom of the **Screening Enrollment** Form on page one *and* page two.

3. All information on the first three pages must be completed by the participant. If any signatures or income information are missing, the **Screening Enrollment** Form will be returned to the provider for completion. This delay in the paperwork process will slow reimbursement to the provider.

4. There must be a dollar amount in the income section; the participant can indicate $0 if that is true. Not applicable (N/A) or a blank is unacceptable.

5. The Visit Summary (page 4), is to be completed by the provider.
   a. If a question is answered "Yes" and a date is requested, and the exact date is not known, please indicate a year.
   b. If a question is answered "No" and there is another selection below "No", you must indicate the appropriate selection(s).
   c. If the mammogram was ordered but paid for by other sources, please indicate the payment source next to the "paid by non-IN-BCCP funds."
   d. If the participant had a hysterectomy, please note whether the hysterectomy was partial or total and check the pathology finding. Pathology needs to documented, not self-reported by the woman. If pathology is undocumented, enter as "pathology unknown" and perform a Pap.

B. Additional Screening Packet Forms

1. HIPAA NOTICE OF PRIVACY PRACTICES (The Yellow Sheet for English and Salmon for Spanish)
   a. Please be sure the Notice of Privacy Practices found in the **Screening Enrollment** Form is given to the participant at her appointment. HIPAA policy requires that IN-BCCP participants receive this documentation yearly.

2. PAP SUMMARY (The Blue Sheet)
    a. This sheet may be used as a referral sheet to the appropriate IN-BCCP provider.

3. BREAST IMAGING SUMMARY (The Pink Sheet)
    a. This sheet may be used as a referral sheet to the appropriate IN-BCCP provider.

C. The Diagnostic Visit Form

1. When to use a **Diagnostic Visit** Form:
    a. **Diagnostic Visit** Forms are to be used following completion of a purple enrollment for any follow-up visits or diagnostic testing done prior to the next annual purple enrollment's completion. Anytime a participant receives an additional procedure (beyond screening), or returns for a different date of service, a new **Diagnostic Visit** Form is necessary for IN-BCCP to track the services rendered (for billing purposes). When participants return for new yearly screening visits, they must be re-enrolled in the program using English (Purple) or Spanish (Ivory) **Screening Enrollment** Form and must re-qualify.

2. Completing the **Diagnostic Visit** Form:
    a. The **Diagnostic Visit** Form must be completely filled out in order to be processed.
        i. Front of the Form
            - Provider should place the site's information under the appropriate section of the medical release.
            - IN-BCCP participants must read, sign and date the front of the form.
            - A signature is only good for 60 days. Without a valid signature on file, reimbursement for services may be denied.
        ii. Back of the Form
            - IN-BCCP participants must complete the upper portion of the form under the Personal Data section.
            - Provider should indicate all procedures that were either performed or ordered during the visit.

3. What to include with the **Diagnostic Visit** Form
    a. An approved Pre-Authorization for **Diagnostic Services** Form must be obtained from the IN-BCCP RN-Case Manager prior to services being rendered and included with the **Diagnostic Visit** Form. A copy of the additional mammographic views, breast ultrasound, breast or cervical biopsy pathology, consultation report, or clinical notes is required and must accompany the **Diagnostic Visit** Form when submitted for payment (*Refer to Reimbursement for Services Provided by Participating Provider section III-B*).

D. Submitting the Completed Forms

1. All completed forms and accompanying documentation are to be sent to the appropriate regional coordinator.

APPENDIX

1. **American Society for Colposcopy and Cervical Pathology: http://www.asccp.org**

2. **National Comprehensive Cancer Network Breast Cancer Screening and Diagnosis guidelines: www.nccn.org/professional/physician_gls/f_guidelines.asp**